Naval Hospital Oak Harbor Prime Health Center
Pre-Adolescent (10yr-12yr) Well Child Visit

Date:

Provider Note **Time:**

Interval History:

Review of Systems:
Menarche:
Past Medical History:

Medications:
Allergies:
Immunizations:
Family Relations:
School/Social Issues:
School Performance:
After School Activities:
Friendships:
Tobacco/Alcohol/Drug Use:
Sexual Activity:
Contraception:
Mood:

Physical Exam

Vital Signs ❒ N/A

Pain: ___ (0-10)

Weight: _____ kg _____ lb _____%ile
Length: _____cm _____ in _____%ile
Body Mass Index: _____ kg/m^2 _____%ile

Temp: _____ HR: _____
RR: _____ **BP**: _____
O2 Sat: _____

Nl	Abn	
❒	❒	General Appearance:
❒	❒	Head:
❒	❒	Eyes:
❒	❒	ENT:
❒	❒	Neck:
❒	❒	Chest:
❒	❒	Heart:
❒	❒	Abdomen:
❒	❒	Genitals:
❒	❒	Musculoskeletal:
❒	❒	Skin:
❒	❒	Neuro:

Vision Screening
Right:
Left:

Assessment

Plan
Anticipatory Guidance
Labs: CBC, Cholesterol
Immunizations: HepB, Td, Influenza
Other:

Follow-up:
Addressograph

_____
Examiner's Signature/Name Stamp

Pre-Adolescent (10yr-12yr) Well Child Visit
Parent Questionnaire

1. How often does your child brush his/her teeth?_____
2. How often does your child see the dentist?_____
3. Do you provide your child healthy food choices and nutritious snacks? Yes/No
4. Does your child have any sleep problems? Yes/No
5. Do you try to regulate your child's television-watching (time, content)? Yes/No
6. Does your child have any responsibilities at home (chores)? Yes/No
7. Are there any smokers in the household? Yes/No
8. Does your child play with matches, candles, lighters, or fireworks? Yes/No
9. Is there is a gun in the home? Yes/No
10. Does your home have working smoke detectors? Yes/No
11. Is your child allowed to play near water unsupervised? Yes/No
12. Does your child wear a life jacket when in a boat? Yes/No
13. Does your child wear a bicycle helmet when riding a bicycle, scooter, or skateboard? Yes/No
14. Do you ever seat your child in front of a passenger air bag? Yes/No
15. Does your child wear a seat belt in the car? Yes/No
16. Do you live or work on a farm? Yes/No
17. Do you help your child with his/her homework? Yes/No
18. Have you talked to your child about puberty/sexuality? Yes/No
19. Have you talked to your child about tobacco, alcohol, and drugs? Yes/No
20. Do you fear for the safety of yourself or members of your family? Yes/No
21. What questions do you have for your child's provider today?